

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town W. Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Murray St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County A. A. Co.City or town W. Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. Murray Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret V. Bailey

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William R. Bailey

7. Birth date of

deceased (mo., day, yr.)

September 9th 1906

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

41416

hrs.

min.

9. Birthplace

Annapolis, A. A. Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Daniel M. C. C. C.

13. Birthplace

Annapolis, Md.

MOTHER

14. Maiden name

Laura Collins

15. Birthplace

Annapolis, Md.

16. Informant

Mrs. W. R. Bailey

Address

W. Annapolis, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

1/28/48
(month) (day) (year)

Cemetery or crematory

Cedar Bluff Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor, Son

Address

Annapolis, Md.

19.

Jan 28 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1948 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1947 to Jan 25 1948and that I last saw him alive on Dec 5 1948

Immediate cause of death

Chs. Pulmonary Tuberculosis

DURATION

6 mos +

Due to

Due to

Other conditions

Shingles mellitus

(Include pregnancy within 3 months of death)

7

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. J. K. K. K. K. K.

M. D. or other

Address Annapolis, Md.Date signed 1/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

00095

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Tenn County Chattanooga
City or town Chattanooga
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chattanooga
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME

Grover Cleveland Bell

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Grace Elliott Bell

7. Birth date of deceased (mo., day, yr.) Sept 30 1892 6. (c) If alive, give age 48 years

8. AGE: Years 55 Months 4 Days 17 If less than one day hrs. min.

9. Birthplace Warsaw Ala.
(Town, county, and state)

10. Usual occupation Times News paper

11. Industry or business John W. Bell

12. Name Warsaw Ala.

13. Birthplace Margaret E. Barnes

14. Maiden name Winston Tex

15. Birthplace Mrs Carrie B. Albright

16. Informant 38 Maryland Ave Annapolis Md.

17. Address Removal Date thereof July 23 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chattanooga Tenn.

18. Locallon John M. Taylor, Son

19. Address Annapolis Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948 at 11 30 p m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1948 to Jan 20 1948 and that I last saw him alive on Jan 20 1948

Immediate cause of death Myocardial infarction
DUE TO Myocardial infarction

Other conditions Ischemic heart disease
(Include pregnancy within 8 months of death)

Major findings of operations Secured
Date of op. Gen.

Autopsy results PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

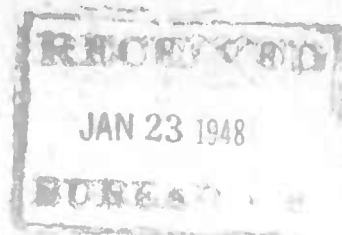
23. SIGNATURE George C. Basil
M. D. or other Annapolis Md.

Date signed 1-21-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 000956

1. PLACE OF DEATH:

County Anne Arundel
 City or town Linthicum Heights
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 yrs
 Hospital, institution, or street address where death occurred:
Patapsco
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Anne Arundel
 City or town Linthicum Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Patapsco
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Jahin Blackwell

3. (b) Social Security Number

none

4. Sex Male 5. Color or race col 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Myrtle Elma Brooks

Blackwell 6. (c) If alive, give age 5:5 years

7. Birth date of deceased (mo., day, yr.) July 19 1922

8. AGE: Years 70 Months 6 Days 3 It less than one day hrs. min.

9. Birthplace Florence S.C.
 (Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business private

12. Name unknown

13. Birthplace "

14. Maiden name May Chapman

15. Birthplace " S.C.

16. Informant Myrtle A. Blackwell

Address Linthicum Heights Patapsco

17. Burial Date thereof Jan 25 48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Patapsco md

Location Patapsco md

18. Funeral director Elroy O. Wilson

Address 1000 Brentley ave

19. Jan 24 19 48 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 19 48 at 9:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 19 47 to Jan 22 19 48

and that I last saw him alive on Jan 21 19 48

Immediate cause of death Myocardial

insufficiency DURATION 6 mo

Due to Cancer of prostate 6 mo?

Due to General arterio sclerosis 2 yrs

Other conditions Hypertension 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Brumback M. D. or other

Address Elkridge Md Date signed 4/22/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 00098

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

one hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Parole nr Annapolis
 (If outside city or town limits, write RURAL and give nearest town)Street No. South River Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ANNA ELIZABETH BRASHEARS

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Charles Lee Brashears

7. Birth date of deceased (mo., day, yr.) June 3, 1914
 6.(c) If alive, give age 33 years

8. AGE: Years 33 Months 7 Days 7 If less than one day
 hrs. min.

9. Birthplace Prince George County, Maryland
 (Town, county, and state)

10. Usual occupation Sect.11. Industry or business Bank12. Name Samuel Coale13. Birthplace Maryland14. Maiden name Helen Griffith15. Birthplace Maryland16. Informant Mr. Charles Lee BrashearsAddress Parole, Anne Arundel, Maryland

17. Burial Date thereof 1-14-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's CemeteryLocation Annapolis, Maryland18. Funeral director Ben L. Hopping and SonAddress Annapolis, Maryland

19. Jan. 13 1948
 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 19 48 at 1145 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 - 9pm, 1948 to Jan 10 - 1145pm 19 48
 and that I last saw him alive on Jan 10 19 48

Immediate cause of death Cerebral Hemorrhage
St. Semi plegia

Due to Hypertension

Due to [Signature]

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George B. Basil
 M. D. or other

Address Annapolis Date signed 1-11-48

Dr. Basit



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County Anne Arundel
 City or town Annapolis Anne Arundel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 hours 10 minutes
 Hospital, institution, or street address where death occurred Emergency Hospital
 How long in hospital or institution? 19 hours 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Edgewater P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Carl Broolin

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Joy Broolin

7. Birth date of deceased (mo., day, yr.) Sept 8, 1903 6. (c) If alive, give age 23 years

8. AGE: Years 44 Months 4 mo. Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Columbus, Mich. Dakota
 (Town, county, and state)

10. Usual occupation Farming

11. Industry or business _____

12. Name Gustav Broolin

13. Birthplace Sweden

14. Maiden name Pauline Broolin

15. Birthplace Hopkyn

16. Informant Robert Lee

Address Shady Side

17. Burial Date thereof Jan 20, 1948
 (Burial, cremation, or removal, Which? (month) (day) (year))

Cemetery or crematory Quaker Lane

Location Galesville Md.

18. Funeral director D. G. Hardisty & Son

Address Galesville Md.

19. Jan. 20, 1948
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1948 at 7-10 p.m.

21. I CERTIFY that death occurred on the date above stated: attended & treated from
Post Mortem Examination
and that I last saw him alive on July 18, 1948

Immediate cause of death _____

Due to Cardio-respiratory failure

Due to 2nd & 3rd degree

Due to burns of neck back

and all extremities 19 hours

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1-17-48

Where did injury occur? Edgewater P.O. Maryland
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury house burned down Injured at work? _____

23. SIGNATURE John M. Caffy M.D. Deputy Medical Examiner

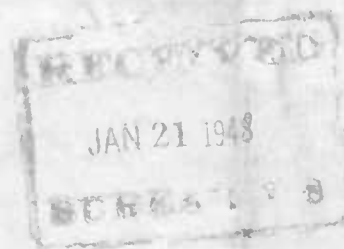
Address Annapolis, Md. Date signed 1-18-48

MARGIN RESERVED FOR BINDING

VS A15

9-45756M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0009921

1. PLACE OF DEATH:

County Anne ArundelCity or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)Street No. 927 Francis Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bessie W. Brown

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Wm H. Brown

7. Birth date of deceased (mo., day, yr.)

June 10th 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71628

hrs.

min.

9. Birthplace

Annapolis A. A. Co. Md.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Benjamin Holliday

13. Birthplace

Annapolis, Md.

MOTHER

14. Maiden name

Julia Hardesty

15. Birthplace

Maryland

16. Informant

William H. Brown

Address

Eastport, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

1/11/48
(month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis Md.

18. Funeral director

John M. Taylor, Son

Address

Annapolis Md.

19.

Jan 11 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8th 19 48 at 10¹⁵ P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 29 19 47 to Jan 8 19 48and that I last saw h. W alive on Jan 8 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 hr

Due to

Arterial Hypertension

Duration

Several years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/9/48

RECORDED
JAN 13 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00100

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
County.....
City or town..... Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Parole Md. near Annapolis
How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Parole Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole, Md. near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war -----

3. (a) FULL NAME

Daniel Edward Brown

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mildred Brown
7. Birth date of deceased (mo., day, yr.) April 2, 1911
8. AGE: Years Months Days It less than one day
36 9 15 hrs. min.

9. Birthplace Parole, Md. near Annapolis
(Town, county, and state)
10. Usual occupation Utility Helper
11. Industry or business None

12. Name Daniel Brown
13. Birthplace Hopes Chapel
14. Maiden name Lottie Brown
15. Birthplace Annapolis, Maryland

16. Informant Mildred Brown
Address Box 10 Route 1 Parole, Md.
17. Burial Date thereof 1- 21- 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Brewer Hill
Cemetery or crematory
Location West Street Extended

18. Funeral director Mrs. Charles E. Hicks
Address 43-45 Northwest Street

19. Jan. 21 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17, 1948, at 4:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1948, to Jan 17, 1948
and that I last saw him alive on Jan 17, 1948

Immediate cause of death Lobar Pneumonia DURATION 7 days

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore H. Chan M.D.
Address 40 Northwest Street Date signed 1/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

00101

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Annapolis
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 hours, 35 minutes
 Hospital, institution, or street address where death occurred:
Annapolis Emergency Hospital
 How long in hospital or institution? 6 hours, 35 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For born infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Davidsonville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. 7. D
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Brown

3. (b) Social Security Number

none

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 25 1936 6. (c) If alive, give age. years

8. AGE: Years 11 Months 11 Days 15 If less than one day hrs. min.

9. Birthplace Davidsonville AA Co Md
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George Brown

13. Birthplace AA Co Md

14. Maiden name Rachael Green

15. Birthplace AA Co Md

16. Informant Rachael Green

Address Davidsonville Md

17. Burial Date thereof Jan 12 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Davidsonville

Location Davidsonville Md

18. Funeral director J A Hardisty & Son

Address Elisville Md

19. Jan 12 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948 at 3:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that Postmortem Examination was made; and that I last saw him alive on Jan 10 1948

Immediate cause of death

Severe Concussion

Due to Brain with

Sub-dural hemorrhage 6 hours
35 minutes

Also Fracture of right femur

Other conditions upper third

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-9-48

Where did injury occur? Davidsonville AA Maryland
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 214

Means of injury automobile (hit & run) Injured at work? No

Signature John M. Coffey M.D. Deputy
Annapolis, Md medical
 M. D. Examiner

Address Annapolis, Md Date signed 1-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 00192
 Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... 7 yrs. 4 mos. Hospital, institution, or street address where death occurred: Crownsville State Hospital How long in hospital or institution?..... 7 yrs. 4 mos.				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Maryland State..... County..... City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town) Street No..... 2501 Francis St., N. W. (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3.(a) FULL NAME MARY A. BROWN				3.(b) Social Security Number			
4. Sex female		5. Color or race negro		6.(a) Single, married, widowed, or divorced married			
6.(b) Name of husband or wife Willard Brown				6.(c) If alive, give age unknown years			
7. Birth date of deceased (mo., day, yr.) 1918				8. AGE: Years 30 Months Days If less than one day hrs. min.			
9. Birthplace Atlantic City, New Jersey (Town, county, and state)				10. Usual occupation Domestic			
11. Industry or business ---				12. Name Robert McQuinn			
13. Birthplace New Jersey				14. Maiden name Veronica Jennings			
15. Birthplace ---				16. Informant Hospital Records Address Crownsville, Maryland			
17. Burial (Burial, cremation, or removal, which?) Date thereof Jan. 23, 1948 Cemetery or crematory Location Baltimore, Maryland 18. Funeral director The George W. Hall Co. Address 1603 1/2 Duval Hill Ave. 19. 1/22/48 (Date rec'd by registrar)				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Injured at work?			
20. DATE OF DEATH January 19 1948 at 9:10 a.m.				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941 to Jan. 1948 and that I last saw her alive on Jan. 1948 Immediate cause of death Tuberculosis of the Spine (cold abscess) known to us since 8/28/47 Other conditions Dementia Praecox known to us since 9/18/40 (Include pregnancy within 8 months of death) Major findings of operations --- Date of op. --- Autopsy results --- PHYSICIAN: Please underline the cause to which death should be charged statistically.			
23. SIGNATURE Jacob M. Mager... Address Crownsville, Md. Date signed 1/19/48				24. SIGNATURE A. W. Hedrick Registrar			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00103

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County Annapolis
 City or town Life
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
88 College Creek Terrace
 How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 88 College Creek Terrace
 (If rural, give LOCATION)
 2. (a) If veteran, name war Life

3. (a) FULL NAME William Norman Brown

3. (b) Social Security Number None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None 6. (c) If alive, give age None years

7. Birth date of deceased (mo., day, yr.) September 4, 1912

8. AGE: Years 35 Months 4 Days 13 If less than one day hrs. min.

9. Birthplace West River Anne Arundel Co. Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Matthews Brown

13. Birthplace West River, Anne Arundel Co. Md.

14. Maiden name Mamie Randall

15. Birthplace West River Anne Arundel Co. Md.

16. Informant Mamie Randall

Address West River Anne Arundel Co. Md.

17. Burial January 22, 1948

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Asbury Cemetery

Location Smithville nr. Annapolis Md.

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. Jan. 22, 19 48

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 48 at 12:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 to Jan 14 and that I last saw him alive on Jan 18

Immediate cause of death Myocardial Infarction, resulting from debilitated condition
Heart Failure
 Due to Patient had Polio at age 18 mos. from this time was debilitated & bedridden. (216-48) 9-5.
 Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. None

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE Dr. T. W. D.

M. D. or other None

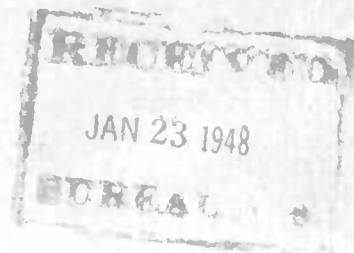
Address 17 Canoe Date signed 1-14-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00104

Reg. Dist. No. 25

1. PLACE OF DEATH:

County A.A. County
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
4400 Gov. Ritchie Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ohio County
City or town Akron
(If outside city or town limits, write RURAL and give nearest town)
Street No. ?
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth E. Bunn

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife David R. Bunn

7. Birth date of deceased (mo., day, yr.) January 8, 1869 6. (c) If alive, give age years

8. AGE: Years 79 Months 3 Days 3 If less than one day hrs. min.

9. Birthplace Decatur, Ind.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name N. Gilson

13. Birthplace Ind.

14. Maiden name M. Ayres

15. Birthplace Ind.

16. Informant Mr. Russell C. Bunn

Address 4400 Gov. Ritchie Highway

17. Burial Date thereof Jan. 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glendale Cemetery

Location Akron, Ohio

16. Funeral director Milton Shilling - Schilling

Address 3914 Hanover st. Baltimore, Md.

19. January 12, 1948 Registrar Ida M. Whelan
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1948 at 10.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1947 to January 11, 1948

and that I last saw him alive on January 10, 1948

Immediate cause of death Heart failure

DURATION 3 wks.

Due to Generalized arterial-sclerosis

and Parkinson's disease

Due to 2 yrs.?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE George A. Kupp M. D. or other

Address 3030 Edmondson Ave. Date signed 1/12/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF VILLAGE CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF NATIONAL CLERK

24. SIGNATURE OF INTERNATIONAL CLERK

25. SIGNATURE OF UNITED NATIONS CLERK

26. SIGNATURE OF WORLD CLERK

27. SIGNATURE OF GALAXY CLERK

28. SIGNATURE OF UNIVERSE CLERK

29. SIGNATURE OF COSMOS CLERK

30. SIGNATURE OF INFINITY CLERK

31. SIGNATURE OF ETERNITY CLERK

32. SIGNATURE OF OMNIPOTENCE CLERK

33. SIGNATURE OF OMNISCIENCE CLERK

34. SIGNATURE OF OMNIBENEDICTICION CLERK

35. SIGNATURE OF OMNIPRESENCE CLERK

36. SIGNATURE OF OMNIPOTENCY CLERK

37. SIGNATURE OF OMNISCIENT CLERK

38. SIGNATURE OF OMNIBENEDICT CLERK

39. SIGNATURE OF OMNIPRESENT CLERK

40. SIGNATURE OF OMNIPOTENT CLERK

41. SIGNATURE OF OMNISCIENT CLERK

42. SIGNATURE OF OMNIBENEDICT CLERK

43. SIGNATURE OF OMNIPRESENT CLERK

44. SIGNATURE OF OMNIPOTENT CLERK

45. SIGNATURE OF OMNISCIENT CLERK

46. SIGNATURE OF OMNIBENEDICT CLERK

47. SIGNATURE OF OMNIPRESENT CLERK

48. SIGNATURE OF OMNIPOTENT CLERK

49. SIGNATURE OF OMNISCIENT CLERK

50. SIGNATURE OF OMNIBENEDICT CLERK

51. SIGNATURE OF OMNIPRESENT CLERK

52. SIGNATURE OF OMNIPOTENT CLERK

53. SIGNATURE OF OMNISCIENT CLERK

54. SIGNATURE OF OMNIBENEDICT CLERK

55. SIGNATURE OF OMNIPRESENT CLERK

56. SIGNATURE OF OMNIPOTENT CLERK

57. SIGNATURE OF OMNISCIENT CLERK

58. SIGNATURE OF OMNIBENEDICT CLERK

59. SIGNATURE OF OMNIPRESENT CLERK

60. SIGNATURE OF OMNIPOTENT CLERK

RECEIVED
JAN 13 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

00105

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town St. Margaretts
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

Colored

B. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Allen Champ

7. Birth date of deceased (mo., day, yr.)

5-21

6. (c) If alive, give age..... years

1896

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Eastport Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 31 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 27 1948 to Jan 31 1948

and that I last saw him alive on Jan 31 1948

Immediate cause of death

Lobar Pneumonia

Due to

Due to

Other conditions

Acute Myocarditis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

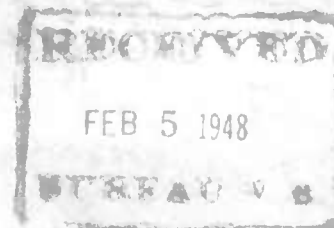
Address

Date signed

R. H. Richardson M.D.

150 - 61st St. Baltimore Md.

Date signed 2/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND-STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d 00196 29

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, institution, or street address where death occurred:

13 Monument St.

How long in hospital or institution?

3. (a) FULL NAME

Joseph Coates

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Josephine Coates

7. Birth date of

deceased (mo., day, yr.)

June 15, 1880

6. (c) If alive, give age..... years

8. AGE:

66 Years

Months

7

Days

5

If less than one day

hrs. min.

9. Birthplace

Davidsonville, Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Joseph Coates

12. Name

Davidsonville, Md.

14. Maiden name

Davidsonville

16. Informant

Mrs. Josephine Coates
Address 13 Monument St.17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

1-25-48
(month) (day) (year)

Cemetery or crematory

Eastbury

Location

Smithfield
William Reese, Jr.

18. Funeral director

1085 Washington St. Annapolis, Md.
Jan. 24, 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anne Arundel

City or town

Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

13 Monument St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 21, 1948, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21, 1948, to Jan. 21, 1948

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Cardiac Failure

DURATION

1 day

Due to

Hypertensive Cardio Vascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. J. J. Johnson
4000 Baltimore Ave.
Annapolis, Md.

M. D. or other

Address

Date signed

1/21/48

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MARYLAND

STATE OF MARYLAND

MEDICAL EXAMINATION

RECORDED

JAN 27 1948

NOTED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00107

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, 14 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 4 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County 2hc
 City or town Salisbury
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2. (a) If veteran, name war World War No. 1 ✓

3. (a) FULL NAME

ISAAC COOK

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Unknown to us
 7. Birth date of deceased (mo., day, yr.) 49 - 1898 6. (c) If alive, give age _____ years
 8. AGE: Years 49 Months ? Days ? If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12th 19 48 at 1:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29th 19 47, to January 12th 19 48and that I last saw him alive on January 12th 19 48

Immediate cause of death General Paresis Known to us since 8-29-47
 DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isaac Cook M. D. or other _____Address Crownsville, Maryland Date signed 1/12/48

16. Informant Hospital Records
 Address Crownsville, Maryland

17. Burial Date thereof Jan 14 - 48
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Wells Green MdLocation Near Salisbury Md16. Funeral director James P. StewartAddress Salisbury Md

19. Jan 10 19 48 Erjoye Pocar
 (Date rec'd by registrar) Registrar

RECEIVED
JAN 15 1948
RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00108

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 33 years, 4 months, 12 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 33 years, 4 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. No home
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MOLLIE COTMOND (COTTON)

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1872
 8. AGE: Years 75 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name Unknown
 13. Birthplace _____
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Hospital Records
 Address Crownsville, Maryland
 17. Burial Date thereof 1/24/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Crownsville Cemetery
 Location Crownsville
 18. Funeral director Dr. H. H. H. H.
 Address Crownsville, Md.
 19. Jan 22 19 48 27 for a Cora
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15th 19 48 at 12:00 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 19 41 to January 15th 19 48
 and that I last saw her alive on January 15th 19 48

Immediate cause of death Myodegeneratio cordis (Arteriosclerosis)
known to us since
6 months
 Due to _____
 Due to _____
 Other conditions Psychosis With Mental
Deficiency (Hemiplegia) known to us
 (Include pregnancy within 3 months of death) since 9/3/1914
 Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Manner of injury _____ Injured at work? _____
 23. SIGNATURE Dr. H. H. H. H. M. D. or other _____
 Address Crownsville, Maryland Date signed 1/15/48

RECEIVED
JAN 27 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00158

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 4 Cheltona Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna Goodrich Leanitt Cresap

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Lt. Comdr. James C. Cresap

7. Birth date of deceased (mo., day, yr.)

December 7th 1860

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

87112

hrs.

min.

9. Birthplace

Offord, Ohio
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

John McDowell Leanitt

13. Birthplace

Steubenville, Ohio

MOTHER

14. Maiden name

Bethie Brooks

15. Birthplace

Cincinnati, Ohio

16. Informant

Logan Cresap

Address

Annapolis, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1/22/48
(month) (day) (year)

Cemetery or crematory

Naval Academy Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor, Inc.

Address

Annapolis, Md.

19. Jan 22 48

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 19 48 at 10 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from M.C. 7 19 47 to Jan 19 19 48and that I last saw him alive on Jan 19 19 49

Immediate cause of death

Central Hemorrhage with left ventricular failure

Due to

Arterio Sclerosis

Due to

Arterial Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

3. SIGNATURE

John M. Taylor, Inc.

M. D. or other

Address

Annapolis, Md.

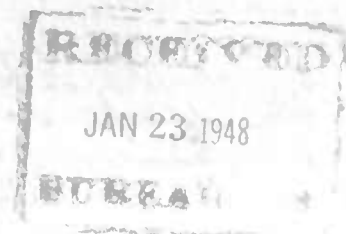
Date signed

Jan 20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 145 Main Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Estelle Crasby

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Richard C. Crasby
 7. Birth date of deceased (mo., day, yr.) July 23rd 1880 6. (c) If alive, give age years
 8. AGE: Years 67 Months 11 Days 21 If less than one day hrs. min.

9. Birthplace A. A. Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Ames Stallings

13. Birthplace A. A. Co., Md.

MOTHER 14. Maiden name Susan Auster

15. Birthplace A. A. Co., Md.

16. Informant Mrs. Joseph Macaluso

Address Annapolis, Md.

17. Buried Date thereof 1/19/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff Cemetery

Location Annapolis, Md.

18. Funeral director John M. Taylor, Inc.

Address Annapolis, Md.

19. Jan 19 1948 John M. Taylor, Inc.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 19 48 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 48 to Jan 16 19 48 and that I last saw him alive on Jan 16 19 48

Immediate cause of death Cerebral Neoplasm
Prothrombosis

Due to Hypertension

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

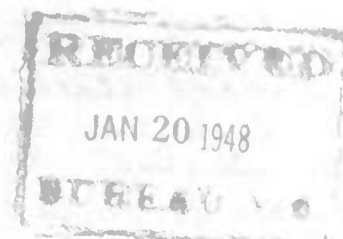
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bond

Address Annapolis, Md. Date signed 1-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

001110

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

McDonough Hall U.S. Naval Academy

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. Luxton Hgts.
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Clavis Deladrier

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Marguerite Deladrier

7. Birth date of deceased (mo., day, yr.)

Jan. 7, 1886

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

62012

..... hrs.

..... min.

9. Birthplace

Belgium
(Town, county, and state)

10. Usual occupation

Fencing instructor U.S. N.A.

11. Industry or business

FATHER

12. Name

Zak Deladrier

13. Birthplace

Belgium

MOTHER

14. Maiden name

Catherine Willock

15. Birthplace

Belgium

16. Informant

Mrs. Clavis Deladrier

Address

Luxton Hgts. A. A. G. Rd.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 27 - 1948
(month) (day) (year)

Cemetery or crematory

Naval Academy

Location

Annapolis, Md.

18. Funeral director

John M. Saylor, Son

Address

Annapolis, Md.

19. Jan. 26

19 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 19 48 at 4 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 - 3:30 P.M. to Jan 24 - 19:48 and that I last saw him alive on Jan 24 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

2 weeks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Bond

M. D. or other

Address Annapolis, Md. Date signed 1-25-48

RECORDED

JAN 27 1948

ST. BEAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00157

Reg. Dist. No.

1. PLACE OF DEATH:

County... Anne ArundelCity or town... Severn
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George E. Diefel

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

JANUARY 30, 1850

7. Birth date of

deceased (mo., day, yr.)

January 20, 1850

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

971117

..... hrs.

..... min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual occupation

Retired FARMER

11. Industry or business

FATHER

12. Name

John H. Diefel

13. Birthplace

Germany

MOTHER

14. Maiden name

Elizabeth Brown

15. Birthplace

Germany

16. Informant

Mrs. Oden Pumphrey

Address

Ferndale, A.A. Co. Maryland

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

1-6-48

(month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Maryland

18. Funeral director

Ben L. Hopping and Son

Address

170-172 West St. Annapolis, Md.

19.

Jan. 5, 1948

(Date rec'd by registrar)

Clara Keshel

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Anne Arundel

City or town

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

SEVERN

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 3 - 1948

at

4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 15

19

47

to

Jan 3 1948

and that I last saw him alive on

Jan 1 - 48

19

Immediate cause of death

Cerebral Thrombosis

DURATION

2 days

Due to

Due to

Other conditions

Cardio Vascular Disease

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date

Jan 3 1948

REPORT OF DEATH

REPORT OF DEATH

REPORTED
FEB 10 1943
FEB 10 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

City or town *Carleigh Heights*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town *Carleigh Heights*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

L. a. Bleit

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 23 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~accidental~~~~accidental~~ *Post-mortem Examination*~~accidental~~ *January 23 1948*

Immediate cause of death

DURATION

Bronchopneumonia 6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

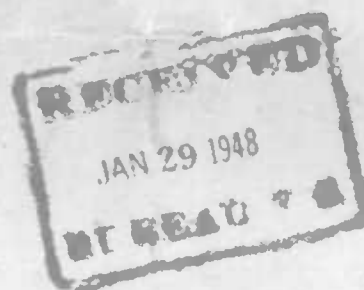
23. SIGNATURE

M. D. or

Address

Date signed

23-49



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00112

Reg. Dist. No. 23

1. PLACE OF DEATH:

County... Anne Arundel

City or town... Severn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel

City or town... Severn, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. Donaldson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Ellsworth Donaldson

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

September 30, 1943.

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4

4

1

hrs.

min.

9. Birthplace University Hospital, Baltimore, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Alfred Donaldson

13. Birthplace

Severn, Md. R.F.D.

MOTHER

14. Maiden name

Lillian Marie Mooney

15. Birthplace

Baltimore, Md.

16. Informant

Howard Donaldson

Address

Severn, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 2, 1948
(month) (day) (year)

Cemetery or crematory Glen Haven Momo. Park

Location Glen Burnie, Md.

18. Funeral director

Thomas W. Singleton

Address

Glen Burnie, Md.

19. 2/2 1948
(Date rec'd by registrar)

1948

L. J. DeAlba

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 - 48, 1948, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 30 - 48 to Jan 31 - 48, 1948

and that I last saw him alive on Jan 30 - 48, 1948

Immediate cause of death

Cerebral Thrombosis (Hemiparesis)

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. J. DeAlba M.D. or other

Address: Severn, Md. Date signed Jan 31 - 48

CERTIFICATE OF DEATH

LOCAL HEALTH OFFICER'S SIGNATURE

DATE OF DEATH

LOCAL HEALTH OFFICER'S NAME

LOCAL HEALTH OFFICER'S ADDRESS

LOCAL HEALTH OFFICER'S PHONE NUMBER

LOCAL HEALTH OFFICER'S TELEPHONE NUMBER

LOCAL HEALTH OFFICER'S SIGNATURE

LOCAL HEALTH OFFICER'S NAME

LOCAL HEALTH OFFICER'S ADDRESS

LOCAL HEALTH OFFICER'S PHONE NUMBER

LOCAL HEALTH OFFICER'S TELEPHONE NUMBER

RECEIVED
FEB 4 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Glen Burnie, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Glen Burnie
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 310 Crain Highway S.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

ELIZABETH W. ENDERLE

3. (b) Social Security Number
NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 8. AGE: Years 67 Months 8 Days 18 If less than one day
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 4, 1880

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Own Home
 12. Name Henry Wolfram
 13. Birthplace Lothra, Germany
 14. Maiden name Amelia Taubert
 15. Birthplace Leipzig, Germany

16. Informant Mrs. Ethel E. Bowen
 Address 310 Crain Hwy. S.W. Glen Burnie, Md.
 17. Burial Burial Date thereof Jan. 26, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woodlawn
 Location Baltimore, Md.
 18. Funeral director Thomas W. Singleton
 Address Glen Burnie, Md.

19. Jan 23 19 48 E. J. O'Connell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22nd 19 48 at 10⁴⁵ P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 21st 19 48 to Jan 22 19 48
 and that I last saw him alive on Jan. 21st 19 48
 Immediate cause of death Respiratory failure
secondary to carcinoma of rectum
& multiple metastases DURATION 7 mos.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations Carcinoma of Rectum
 Date of op. ?
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J. V. Paul Timber M.D. M. D. or other
201 Bldg. Annapolis Bldg. Date signed Jan 22 1948

RECORDED

JAN 26 1948

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

00114

93d

1. PLACE OF DEATH:

County BaltimoreCity or town Brooklyn - 25
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yr

Hospital, institution, or street address where death occurred:

715 Hammonds LaneHow long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Ad.City or town Baltimore 25
(If outside city or town limits, write RURAL and give nearest town)Street No. 715 Hammonds Lane
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Engelberger

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Joseph Engelberger7. Birth date of deceased (mo., day, yr.) Sept. 19, 1884 5. (c) If alive, give age 72 years8. AGE: Years 62 Months 5 Days 5 If less than one day
.....hrs.min.8. Birthplace Hungary
(Town, county, and state)10. Usual occupation house wife11. Industry or business Own Home12. Name UNKNOWN13. Birthplace Austria Hungary14. Maiden name UNKNOWN15. Birthplace Austria Hungary16. Informant Mr Joseph EngelbergerAddress 715 Hammonds Lane - Brooklyn 25, Md R.F.D.17. Burial Date thereof Jan 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy CrossLocation Brooklyn R.F.D. A.A. Co. Md18. Funeral director Thomas W SingletonAddress Glen Burnie, Md.19. Jan 26 1948 L. B. B. B.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1948, at 11:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 25 1947 to Jan 24 1948and that I last saw her alive on Jan - 24 1948Immediate cause of death Cardio-Vascular Disease

DURATION

7 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

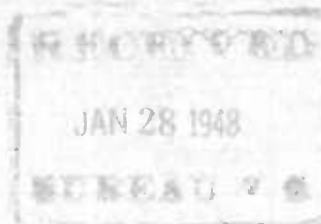
23. SIGNATURE Chas. L. Bace Jr M. D. or otherAddress Litchfield Md Date signed 1-24-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1947
CS
48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A. Co.
City or town Jessup (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Jessup (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elmora L. M. Evans

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Ellsworth H. Evans

7. Birth date of deceased (mo., day, yr.) April 30, 1882. 6.(c) If alive, give age years

8. AGE: Years 65 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Hom.

11. Industry or business Cornelius Sowers

12. Name Baltimore, Md.

13. Birthplace Baltimore, Md.

14. Maiden name Mary C. Greenwood

15. Birthplace Virginia

16. Informant Mrs. Charles Schneider

Address Pikesville, Md.

17. Burial Date thereof 1/31/48 (month) (day) (year)

Cemetery or crematory Meadowridge Mem. Park

Location Dorsey, Md.

18. Funeral director Wm. Cook

Address 1217 St. Paul St., Balt., Md.

19. Date rec'd by registrar January 30, 1948 Registrar R. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1947 to Jan 27 1948 and that I last saw him/her alive on Jan 27 1948

Immediate cause of death Gastric Carcinoma DURATION 6 mos.

Due to ✓

Due to ✓

Other conditions ✓

(Include pregnancy within 8 months of death)

Major findings of operations Gastric Carcinoma

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury Injured at work?

Signature Frank Shipley, M.D.

Address Savage, Md. Date signed 1/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00116

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

104 West Street, Annapolis, Md.How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 164 West Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (a) FULL NAME

Albert William FISCHL

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Edith LaVerne Fischl - wife

7. Birth date of deceased (mo., day, yr.)

June 5, 19106. (c) If alive, give age 30 years

8. AGE:

Years

Months

Days

If less than one day

3874

hrs.

min.

9. Birthplace

Allentown, Pennsylvania

(Town, county, and state)

10. Usual occupation

U.S. Navy

11. Industry or business

FATHER

12. Name

Not available

13. Birthplace

MOTHER

14. Maiden name

Not available

15. Birthplace

16. Informant U.S. NAVY records

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 1-14-48

(month) (day) (year)

Cemetery or crematory

Location Whitter, Calif18. Funeral director Ben L. Hopping and SonAddress 170-172 West St. Annapolis, Md.19. Jan. 13 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 48 at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 9 19 48 to January 9 19 48and that I last saw him alive on January 9 19 48Immediate cause of death Thrombosis, coronary artery

DURATION

Due to Coronary arteriosclerosisDue to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations No operationDate of op. -----Autopsy results Above plus pulmonary edema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -----Date of -----Where did injury occur? -----

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) -----Means of injury -----Injured at work? -----

23. SIGNATURE

John M. Caffrey, M.D.
Annapolis, Md.

M. D. or other

Date signed 1-13-48

RECEIVED
JAN 14 1948
DEERB 60

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County... Anne ArundelCity or town... Crownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years 10 months 8 daysHospital, institution, or street address where death occurred:
Crownsville State HospitalHow long in hospital or institution? 8 years 10 months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... HowardCity or town... Lisbon
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war... ✓

3. (a) FULL NAME

Melvin Fisher

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Unknown

7. Birth date of

deceased (mo., day, yr.) Unknown

6. (c) If alive, give age _____ years

8. AGE:

approx 63 Months

Days

Unknown

If less than one day

Unknown

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

William Fisher

12. Name

13. Birthplace

Marcella Dyles

14. Maiden name

15. Birthplace

Hospital records

16. Informant

Crownsville, Md

Address

Burial Date thereof Jan 14, 48
(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory

Poplar Spring, Md.

Location

Ray W. Barber

18. Funeral director

Saytonville Maryland

Address

1/11/48 E. F. Joyce Local
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 10th 19 48 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 14, 1947 to Jan 10, 1948and that I last saw him alive on January 10, 1948

Immediate cause of death

Chronic myocarditis

DURATION

known for3 years

Due to

Due to

Other conditions

manic-depressive psychosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Jacob Hargreaves M.D. M. D. or other _____Address _____ Date signed 1/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

00118

1. PLACE OF DEATH:

County A. A.
 City or town Clearview Village
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.
 City or town Clearview Village
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

FRANCES KATHARINE FORREST

3. (b) Social Security Number

4. Sex fem. 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Charles W. Forrest
 6. (c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) Feb. 6, 1894
 8. AGE: Years 53 Months II Days I4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation housewife

11. Industry or business

12. Name William Baeke
 13. Birthplace Baltimore, Md.
 14. Maiden name Louise Gross
 15. Birthplace Germany

16. Informant Charles W. Forrest
 Address P. O. Pasadena, Md.

17. Burial Date thereof I-24-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Western Cemetery
 Location _____

19. Funeral director W. J. Tickner & Sons
 Address North & Penna. ayes., Baltimore

19. I-20 48 L. A. Bleit
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 19 48 at 5 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from I-20 19 48 to I-20 19 48 and that I last saw him er alive on I-20 19 48

Immediate cause of death Cerebral hemorrhage DURATION 2 hrs.

Due to Arteriosclerosis and hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

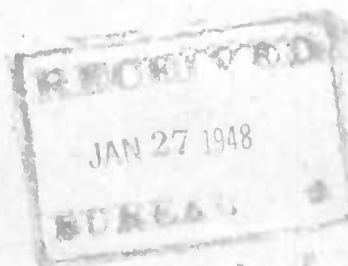
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Leo A. Bleit M.D. M. D. or other

Address Pasadena Md I-20-48 Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

179X

0011922
Reg. Dist. No.

1. PLACE OF DEATH:

County..... A.A.
City or town..... Jessups, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 4 mo.
Hospital, institution, or street address where death occurred:
4 month
How long in hospital or institution?..... 16 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... A.A.
City or town..... Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war..... No

3. (a) FULL NAME

Issac Gainor

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Col'd 6. (a) Single, married, widowed, or divorced..... Married
6. (b) Name of husband or wife..... Helen
7. Birth date of deceased (mo., day, yr.)..... Jan. 7, 1915
8. AGE: Years..... 33 Months..... ----- Days..... 13 If less than one day..... --- hrs. --- min.
9. Birthplace..... Ironsides, Charles Co.
(Town, county, and state)
10. Usual occupation..... Laborer
11. Industry or business..... ---
12. Name..... Issac Gainor
13. Birthplace..... Maryland
14. Maiden name..... Bertie
15. Birthplace..... Maryland

16. Informant..... Md. House Correction,
Address..... Jessups, Maryland
17. Removal Date thereof..... Jan 27 - 48
(Burial, cremation, or removal Which?) (month) (day) (year)
Cemetery or crematory..... Payne Cemetery
Location..... Washington D.C.
18. Funeral director..... Montgomery Bros.
Address..... 713 Fla ave n w
19. Jan 24 19 48 Clare Rashed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 20, 19 48 at 9:40A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....
and that I last saw h..... alive on.....19.....

Immediate cause of death.....

Poisoning from drinking radiator anti-freeze solution.

Due to.....

Exact type of solution

Due to.....

pending chemical analysis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 1-19-48
Where did injury occur?..... Solomon's Island Camp, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Same as aboveMeans of Injury..... Rad. Anti-freeze Injured at work?..... Yes

23. SIGNATURE.....

John M. Claffy
John M. Claffy, M.D. D. or other
Address..... Deputy Med. Exam. Date signed..... 1-20-48.
Annapolis, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

00120

93d

1. PLACE OF DEATH:

County Anne Arundel Co.
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, institution, or street address where death occurred:
31 Larkins St.
How long in hospital or institution? *****

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 31 Larkins St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Louisa Giles

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife *****
6.(c) If alive, give age *** years
7. Birth date of deceased (mo., day, yr.) February 29, 1889
8. AGE: Years 58 Months Days If less than one day hrs. min.

9. Birthplace Davidsonville A. A. Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None
12. Name Henry Carroll
13. Birthplace Davidsonville
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs Annie Willard
Address 31 Larkins St. Anna polis Md.
17. Burial Date thereof January 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brewer Hill Cemetery
Location West St. extd. Annapolis Md.
18. Funeral director Mrs Charles E. Hicks
Address 45 Northwest St. Annapolis Md.
19. Jan 3, 48 Registrar W. J. Carroll
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 48 at 9:30 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-12 19 46 to 1-1 19 48
and that I last saw him alive on 12-21 19 47
Immediate cause of death arteriosclerotic heart
Disease
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE W. J. Carroll M. D. or other
Address 17 Anney Date signed 1-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

82
001212 2
Reg. Dist. No.

1. PLACE OF DEATH:

County... Anne Arundel
City or town... Laurel (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, institution, or street address where death occurred:
District Training School
How long in hospital or institution? 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel
City or town... Laurel (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced
single

6.(b) Name of husband or wife... none
6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) October 7, 1908
8. AGE: Years 47 Months 3 Days _____ If less than one day
_____ hrs. _____ min.

9. Birthplace... Maryland
(Town, county, and state)

10. Usual occupation... none
11. Industry or business... none

12. Name... Webster Goode
13. Birthplace... Maryland
14. Maiden name... Emma (Goode)
15. Birthplace... Maryland

16. Informant... History at District Training School
Laurel, Maryland

Address _____
17. Burial Date thereof... Jan 13 - 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory... Cedar Hill
Location... Switzland Md.

18. Funeral director... W. W. Chambers Co.
Address... 1400 Chapin St. N.W.

19. Jan 14 1948 Lolana Krasluk
Date rec'd by registrar) _____ Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 10, 1948 at 4:32 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 15, 1940 to January 1948
and that I last saw her alive on January 10, 1948

Immediate cause of death... Pneumonia (Bilateral Broncho) 8 days
DURATION

Due to... _____
Due to... _____

Other conditions... Mental Deficiency-Imbecile life
Myotrophic lateral sclerosis ? life
(Include pregnancy within 3 months of death)

Major findings of operations... _____ Date of op. _____

Autopsy results... _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide... _____ Date of... _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE... Richard O'Suff MD
M. D. or other _____
Address... Laurel, Md Date signed... 1/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 23 1948

BUREAU T.S.

RECEIVED
JAN 23 1948

BUREAU T.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. *81a* *00122* *21*1. PLACE OF DEATH *Anne Arundel*County *Crownsville*City or town *Crownsville*
(if outside city or town limits, write RURAL and give nearest town)How long in above place of death? *22 days*

Hospital, institution, or street address where death occurred:

*Crownsville State Hospital*How long in hospital or institution? *22 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* CountyCity or town *Baltimore*
(if outside city or town limits, write RURAL and give nearest town)Street No. *619 Greenwillow St.*
(if rural, give LOCATION)2. (a) If veteran, name war *---* ✓

3. (a) FULL NAME

MINNIE GWYNN

3. (b) Social Security Number

4. Sex <i>female</i>	5. Color or race <i>negro</i>	6. (a) Single, married, widowed, or divorced <i>divorced</i>
-------------------------	----------------------------------	---

6. (b) Name of husband or wife *---*7. Birth date of deceased (mo., day, yr.) *August 19, 1914*

8. AGE:	Years	Months	Days	If less than one day
	<i>33</i>	<i>5</i>	<i>3</i>	<i>hrs. min.</i>

9. Birthplace *North Carolina*
(Town, county, and state)10. Usual occupation *Housework*11. Industry or business *---*12. Name *Richard Graham*13. Birthplace *N. C.*14. Maiden name *Minnie Spencer*15. Birthplace *Virginia*16. Informant *Hospital records*Address *Crownsville, Md.*17. *Burial* Date thereof (month, day, year)Cemetery or crematory *Cheerly Cemetery*Location *Winston Salem, N. C.*18. Funeral director *A. Halstead*Address *918-11th St. N.E.*19. *2-3* *48* *McGee*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 28, 1948* at *10:50 a.m.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *January 6, 1948* to *Jan. 28, 1948*
and that I last saw him alive on *Jan. 28, 1948*Immediate cause of death *Pachymeningitis - Hemorrhagica interna* DURATION *2 days*

Due to

Due to

Other conditions *Alcoholic Hallucinosi-* Known to us
Mental Deficiency since *1/6/48*
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE *Jacob M. Carpenter M.D.* M. D. or otherAddress *Crownsville, Maryland* Date signed *1/28/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

001231

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 7 years
 Hospital, institution, or street address where death occurred:
 17 Franklin St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 17 Franklin St.
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Edward Hall, Jr.

3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... M
 6. (b) Name of husband or wife..... Mrs. Margaret Stutts Hall
 6. (c) If alive, give age..... 63 years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 31, 1880
 8. AGE: Years..... 67 Months..... 0 Days..... 4 If less than one day..... hrs. min.

9. Birthplace..... millersville, a. a. co., md.
 (Town, county, and state)

10. Usual occupation..... Lawyer

11. Industry or business.....

12. Name..... Edward Hall

13. Birthplace..... millersville, md.

14. Maiden name..... Eva Spencer Wallis

15. Birthplace..... Louisiana

16. Informant..... Elizabeth Hall

Address..... 17 Franklin St.

17. Burial Date thereof..... Jan 6, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Stephens Church

Location..... Christfield, a. a. co. md.

18. Funeral director..... John W. Taylor, Son

Address..... Annapolis, Md.

19. Jan. 5, 1948 (Date rec'd by registrar)

W Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 4, 1948, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from month..... 1947, to Dec. 29, 1947, and that I last saw him alive on Dec. 29, 1947, 19.....

Immediate cause of death.....

DURATION

Acute dilatation of heart
 Due to..... Hypertensive cardiovascular disease 8 years
 Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

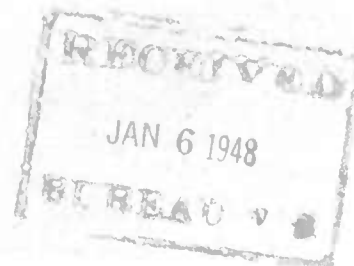
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... E. Peyton Ritchings, M.D.

M. D. or other

Address..... Annapolis, Md. Date signed..... Jan. 9, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00124

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
County Annapolis Md.
City or town 37 years
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred:
52 Northwest St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A. Co.
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Northwest
(If rural, give LOCATION)
2(a) If veteran, name war World war I

3. (a) FULL NAME Joseph Hillery

3. (b) Social Security Number none

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary C. Hillery 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1888

8. AGE: Years 59 Months 4 Days 10 It less than one day hrs. min.

9. Birthplace Davidsonville A. A. Co Md
(Town, county, and state)

10. Usual occupation Electricians Helper

11. Industry or business none

12. Name Henry Hillery

13. Birthplace Davidsonville Md.

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs Mary C. Hillery

Address 52 Northwest St

17. Burial Date thereof January 13-48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Bruner Hill

Location West St. extended

18. Funeral director Mrs Charles P. Hicks

Address 45 Northwest St Annapolis

19. Jan. 12 48

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7, 1948 at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10, 1947 to Jan 7, 1948
and that I last saw him alive on 19

Immediate cause of death Leucemia of stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas H. Johnson M.D.

Address 45 Northwest St Date signed 1/12/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 13 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

00125

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.0 days
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 3.0 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Rural - Davidsonville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Riva Rd.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Maggie Hillary

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife George Hillary

7. Birth date of deceased (mo., day, yr.) Aug. 1895

8. AGE: Years 62 Months 5 Days If less than one day hrs. min.

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name John W. Snowden

13. Birthplace A. G. Co. Md.

14. Maiden name Janette Snowden

15. Birthplace A. G. Co. Md.

16. Informant George Hillary

Address Davidsonville, Md.

17. Burial Date thereof Jan. 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Davidsonville

Location Davidsonville, Md.

18. Funeral director J. B. Johnson

Address Annapolis Md. P.O. Box 462

19. Jan. 18, 48 Registrar J. B. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1948, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 16, 1947, to Jan. 15, 1948

and that I last saw him alive on Jan. 15, 1948

Immediate cause of death Cardiovascular failure

Due to Portal cirrhosis of liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

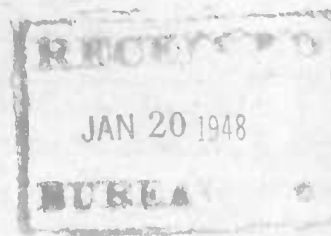
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Peyton Ritchner, M.D.

M. D. of other

Address Annapolis, Md. Date signed Jan. 15, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

87d

Not
CB

00126

Reg. Dist. No. 28

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Washington, D. C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1818 Coran
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

BRADY HOFFMAN

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of husband or wife
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) May 4, 1919
 8. AGE: Years 28 Months 8 Days 24 If less than one day
 ... hrs. ... min.

9. Birthplace... North Carolina
 (Town, county, and state)
 10. Usual occupation... Truck Driver
 11. Industry or business
 FATHER 12. Name Brady Hoffman
 13. Birthplace North Carolina
 MOTHER 14. Maiden name... Jula Saunders
 15. Birthplace South Carolina

16. Informant... Hospital Records
 Address Crownsville, Maryland

17. Burial Date thereof Jan 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington Nat'l Cemetery
 Location Washington, D. C.

18. Funeral director John E. Robinson License #75
 Address 1313-16th St. N.W. Wash., D.C.

19. Jan 30 19 48 E. J. Jones Local
 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28th 19 48 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 20th 19 48 to January 28th, 48
 and that I last saw him alive on January 27th 19 48

Immediate cause of death Multiple Sclerosis Known to us
 since 1/20/48

Due to...
 Due to...

Other conditions Psychosis With Multiple Sclerosis Known to us
 since 1/20/48
 (Include pregnancy within 3 months of death)

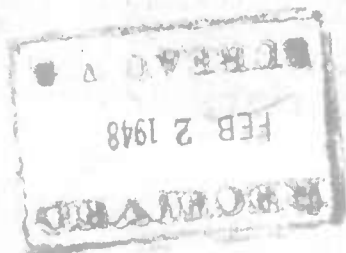
Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury injured at work?

23. SIGNATURE Jacob Margenester M.D. M. D. or other
 Address Crownsville, Maryland Date signed 1/28/48



Clarence Kahn
Williams
Shroder St.
Baltimore
Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00159

Reg. Dist. No.

L 4747

1. PLACE OF DEATH:

County Anne ArundelCity or town Pumphrey
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

300 Berlin AveHow long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Anne ArundelCity or town Pumphrey
(If outside city or town limits, write RURAL and give nearest town)Street No. 300 Berlin Ave
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

James Edward Humphrey

3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife Blanche Smith Humphrey

7. Birth date of deceased (mo., day, yr.)

Dec. 18, 18876. (c) If alive, give age 60 years

8. AGE:

60

Months

Days

If less than one day

hrs. min.

9. Birthplace

Florida
(Town, county, and state)

10. Usual occupation

Contractor

11. Industry or business

FATHER

12. Name

George Humphrey

13. Birthplace

Fla.

MOTHER

14. Maiden name

Unknown

15. Birthplace

Fla

16. Informant

Mrs. Blanche Humphrey

Address

300 Berlin Ave

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1-31-48
(month) (day) (year)

Cemetery or crematory

Mt. Auburn Cem

Location

Baltimore Md

18. Funeral director

Matthias & Hummel

Address

578 W. Biddle St.

19.

1/30
(Date rec'd by registrar)

19

48R. D. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 19 48 at 4:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19 46 to Jan 26 19 48and that I last saw him alive on Jan 26 19 48Immediate cause of death Cerebral Hemorrhage

DURATION

?

Due to

Arterio-sclerosis

Due to

Other conditions

Cystitis, Prostatitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Hedrick

M. D. or other

Address 501 Cherry Hill Rd.Date signed 1-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00127

Reg. Dist. No. 28

1. PLACE OF DEATH: County... <u>Anne Arundel</u> City or town... <u>Crownsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 1/2 mos.</u> Hospital, institution, or street address where death occurred: <u>Crownsville State Hospital</u> How long in hospital or institution? <u>2 1/2 mos.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Maryland</u> County... City or town... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>803 Franklin St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war...	
---	--	--	--

3. (a) FULL NAME <u>LLOYD JACKSON</u>	3. (b) Social Security Number
---	--------------------------------------

4. Sex <u>male</u>	5. Color or race <u>negro</u>	6. (a) Single, married, widowed, or divorced <u>unknown</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife ---	6. (c) If alive, give age --- years
---------------------------------------	--

7. Birth date of deceased (mo., day, yr.) <u>unknown</u>

8. AGE:	Years	Months	Days	If less than one day
<u>approximately 60 years</u>				hrs. min.

9. Birthplace <u>unknown</u> (Town, county, and state)
--

10. Usual occupation <u>unknown</u>
--

11. Industry or business <u>Unknown</u>
--

12. Name

13. Birthplace

14. Maiden name <u>Unknown</u>

15. Birthplace

16. Informant <u>Hospital records</u>
--

Address <u>Crownsville, Maryland</u>

17. <u>Burial</u> (Burial, cremation, or removal. Which?)	Date thereof <u>1/16/48</u> (month) (day) (year)
--	--

Cemetery or crematory <u>mt Auburn</u>

Location <u>md</u>

18. Funeral director <u>Wes. H. Nelson</u>

Address <u>1303 Presstman St</u>

19. <u>1/15/48</u> (Date rec'd by registrar)	<u>A. W. Hedrick</u> Registrar
---	-----------------------------------

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 19 48 at 8:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 2 19 47 to Jan. 13 19 48
 and that I last saw h. alive on January 13 19 48

Immediate cause of death known to us
General Arteriosclerosis since DURATION 12/2/47

Due to

Due to Psychosis with Cerebral
Arteriosclerosis known to us since DURATION 12/2/47

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob Mengersten M.D. M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00128

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Northwest St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, divorced

Married

6. (b) Name of husband or wife

Amy E. Jewell

7. Birth date of deceased (mo., day, yr.)

December 31st 1875

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73019

hrs.

min.

9. Birthplace

Annapolis, A.A.Co. Md.
(Town, county, and state)

10. Usual occupation

Ret. Blacksmith U.S.M.

11. Industry or business

FATHER

12. Name

Joseph Jewell

13. Birthplace

Maryland

MOTHER

14. Maiden name

Priscilla Hopkins

15. Birthplace

Maryland

16. Informant

Mrs. Frank Jewell

Address

Annapolis, Md.

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

1/22/48
(month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor, Son

Address

Annapolis, Maryland

19. (Date rec'd by registrar)

Jan. 22 1948

(Registrar)

23. SIGNATURE

George C. Basil

M. D. or other

Address

Annapolis, Md.Date signed 1. 21. 48

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1947 to Jan 1948
and that I last saw him alive on Jan 19 1948

Immediate cause of death

Carcinoma Stomach

DURATION

8 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Carcinoma of entire stomachDate of op. July 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Basil

M. D. or other

Address

Annapolis, Md.Date signed 1. 21. 48

RECEIVED

JAN 23 1948

STREAN, S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 4mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Parole nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

EDITH MAY JONES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William Edward Jones7. Birth date of deceased (mo., day, yr.) Feb. 5, 1865

6.(c) If alive, give age _____ years

8. AGE:	Years	Months	Days	If less than one day
82	11	1	_____ hrs.	_____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation House wife

11. Industry or business _____

12. Name Joseph O. Fowler13. Birthplace Maryland14. Maiden name Kate S. Leitch15. Birthplace Maryland16. Informant Mr. William S. JonesAddress Parole, Maryland17. Burial Date thereof 1-17-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Davidsonville MethodistLocation Davidsonville, Maryland18. Funeral director Ben L. Hopping and SonAddress 170-172 West St. Annapolis, Md.19. Jan. 17, 1948 W. H. Hopping
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1948, at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 Dec. 1946, to 13 Jan. 1948and that I last saw him alive on Jan. 13, 1948

Immediate cause of death _____

DURATION

Cardiorespiratory failure

Due to _____

Chronic nephritisDue to (glomerulonephritis)

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. Peyton Kitchener, M.D.
M. D. or other _____Address Annapolis, Md. Date signed Jan. 13, 1948

RECEIVED

JAN 20 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Point Pleasant - P.O. Brooklyn 25
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Point Pleasant (-Brooklyn 25-Md P.O.)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Salon Knight

3. (b) Social Security Number

NONE.

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married.

6. (b) Name of husband or wife

Emma Rieg.

6. (c) If alive, give age

27 years

7. Birth date of deceased (mo., day, yr.)

April 19 - 1875

8. AGE:

Years

Months

Days

If less than one day

7295

hrs.

min.

9. Birthplace

Odenton, Md.
(Town, county, and state)

10. Usual occupation

Farming. (Retired)

11. Industry or business

General

FATHER

12. Name

Dennis G. Knight.

13. Birthplace

Anne Arundel Co.

MOTHER

14. Maiden name

Marjory E. Turner

15. Birthplace

Anne Arundel Co.

16. Informant

Mrs. Salon Knight (wife)

Address

Point Pleasant, Md.

17.

Burial
(Burial, cremation, or removal: Which?)

Date thereof

1/27
(month) (day) (year)

Cemetery or crematory

Nichol Memo. Church

Location

Odenton, Md.

18. Funeral director

Thomas W. Singleton

Address

Glen Burnie, Md.

19.

Jan 26
(Date rec'd by registrar)19 48F. J. O'Callahan
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death

DURATION

General asphyxia
 ?

Due to

Suspected
 ?

Due to

Had gradually failing in health
No further information

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NONE Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Emmanuel K. Ramey
Physician

23. SIGNATURE

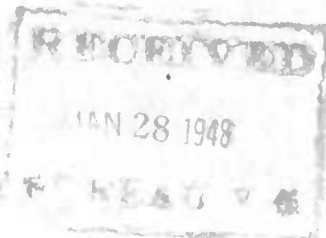
John W. Ramey
Physician
Address: _____
Date signed: 1/24/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00131

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Annapolis, Md.
City or town Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Dec. 29, 1947.
Hospital, institution, or street address where death occurred: Emergency Hospital - Annapolis, Md.
How long in hospital or institution? Since Dec. 29, 1947.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO
City or town BALTO
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2902 Parkwood Ave
(If rural, give LOCATION)
2. (a) If veteran, name war No

3. (a) FULL NAME

Georgianna Land

3. (b) Social Security Number

No

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed.

6. (b) Name of husband or wife Andrew Jackson Land
not living

7. Birth date of deceased (mo., day, yr.) March 4, 1874

8. AGE: Years 73 Months 9 Days 22 If less than one day hrs. min.

8. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation House

11. Industry or business House

12. Name John Davis

13. Birthplace Baltimore, Md.

14. Maiden name Elizabeth Pierant

15. Birthplace Baltimore, Md.

16. Informant Robert E. Land

Address Baltimore, Md.

17. BURIAL Date thereof 1/5/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LODGE PARK

Location BALTO., MD.

18. Funeral director WM. J. TICKNER & SONS INC

Address Port & PA. BALTO., MD.

19. 1/2 19 48 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1948 at 3:12 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29, 1947 to January 1, 1948

and that I last saw her alive on January 1, 1948

Immediate cause of death Acute dilatation of the heart

DURATION 9 months

Due to Arteriosclerotic Cardiovascular disease

Other conditions 2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations Arteriosclerotic Cardiovascular disease

Date of op. 2 yrs.

Autopsy results Arteriosclerotic Cardiovascular disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of 1/5/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE Albert P. Anderson MD

M. D. or other MD

Address Annapolis, Md. Date signed 1/1/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 00133

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1. 11. 1948

at

11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1. 4. 1948, to 1. 11. 1948, and that I last saw him alive on 1. 8. 1948.

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. D.

Address

Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00132

Reg. Dist. No. 105-18

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 4 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.
 City or town Piscataway
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JAMES F. MUNSON

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Munson

7. Birth date of deceased (mo., day, yr.) ? 1882 6. (c) If alive, give age _____ years

8. AGE: Years 66 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Raff Munson13. Birthplace Maryland14. Maiden name Susan Booze15. Birthplace Maryland16. Informant Hospital RecordsAddress Crownsville, Maryland

17. Burial Date thereof 1-30-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Marys
Piscataway

Location St Marys18. Funeral director WadleyAddress Wadley

19. Jan 29 1948 M. F. Munroe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27th 1948 at 10:00P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 23rd 1948 to January 27th 1948
 and that I last saw him alive on January 27th 1948
 Immediate cause of death Cerebral Hemorrhage

DURATION
24 hrs.

Due to Generalized and Cerebral
Arteriosclerosis

Due to _____

Other conditions Senile Psychosis- Delirious
and Confused Type Known to us since
 (Include pregnancy within 3 months of death) 12/23/1947

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)

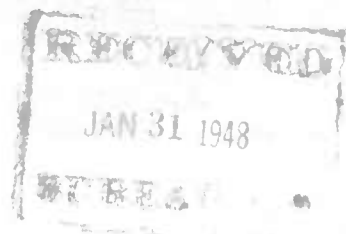
Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James Munson M.D. or other
 Address Crownsville, Maryland Date signed 1/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1220 00134 20

Reg. Diat. No.

1. PLACE OF DEATH:

County Anne ArundelCity or town Cumbersstone
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Roberta Nick

3. (b) Social Security Number

4. Sex Female 5. Color or race negro 6. (a) Single, married, widowed, or divorced —

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1947

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
2 hrs. min.9. Birthplace Cumbersstone, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James Nick13. Birthplace Shadeside Md.14. Maiden name Carrie Brown15. Birthplace Cumbersstone16. Informant Carrie BrownAddress Cumbersstone17. Burial Date thereof 1-6-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chew ChapelLocation Owensville, Ind.18. Funeral director William Reese, IIAddress 108 Washington St.19. Jan 6, 1948 M. J. Clayton Registrar
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For those born in Maryland, give residence of mother)

State Maryland County Anne ArundelCity or town Cumbersstone
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4, 1948 at 6:30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination and that I last saw him Jan 4, 1948 alive on

Immediate cause of death DURATION

Convulsions
Strangled
sublethal trauma

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

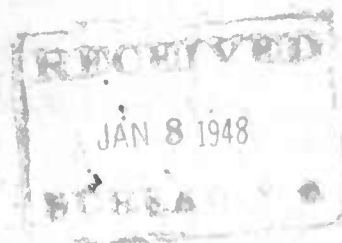
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? Reptile Medical Examination23. SIGNATURE John M. Caffey M.D. M. D. or otherAddress Annapolis Md Date signed 1-4-48



Reg. Diat. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3/14/1911
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 35 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent County
 City or town Locust Grove
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

ROBERT PALMER

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) 1873 6.(c) If alive, give age _____ years
 8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Unknown
 11. Industry or business _____
 12. Name _____ (dead)
 13. Birthplace _____ (dead)
 14. Maiden name _____
 15. Birthplace _____

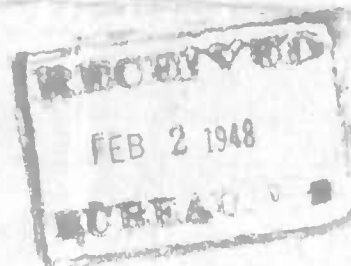
16. Informant Hospital records
 Address Crownsville, Md.
 17. Burial Date thereof 1/30/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hospitale
 Location Crownsville
 18. Funeral director Rev. R. R. R. R. R.
 Address Crownsville Md
 19. Jan 30 19 48 E. J. Joyce Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 19 48 at 10:15P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41, to Jan. 17 19 48
 and that I last saw him alive on Jan. 17 19 48
 Immediate cause of death Myocarditis
(arteriosclerosis) known to
us since DURATION Sept. 1947
 Due to _____
 Due to _____
 Other conditions Manic depressive psychosis
known to us since 11/23/13
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 _____ Date of op. _____
 Autopsy results Marasmus-Senilis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Jacob Hanyante M.D. M. D. or other _____
Crownsville, Md. Date signed 1/17/48
 Address _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00137

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Mago Vista
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs
 Hospital, institution, or street address where death occurred:
Mago Vista
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Mago Vista
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. nr Annapolis, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES H. PARKER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Gertrude A. Parker
 7. Birth date of deceased (mo., day, yr.) October 6, 1868
 8. AGE: Years 79 Months 3 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace New Jersey
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant L.H. Schooler
 Address Mago Vista

17. Burial 1-18-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cemetery
 Location Highstown, New Jersey

18. Funeral director Ben L. Hopping and Son
 Address 170-172 West St. Annapolis, Md.

19. Jan 17 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15, 1948 at 2:00 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 47 to Jan 15, 1948
 and that I last saw him alive on Jan 15, 1948
 Immediate cause of death Coronary Thrombosis
 Due to Chronic myocarditis 5 yrs.
 Due to Hypertensive Cardiovascular disease 10 yrs.
 Other conditions Cachexia
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James R. Martin, M.D.
 Address Annapolis, Md. Date signed 1-16-48

RECEIVED

JAN 20 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hspt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Millersville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Irvin W. Pumphrey

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Addie E. Pumphrey

7. Birth date of deceased (mo., day, yr.)

July 1st 1901

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

4614

hrs.

min.

9. Birthplace

A. A. Co. Md.
(Town, county, and state)

10. Usual occupation

Plasterer

11. Industry or business

FATHER

12. Name

John Pumphrey

13. Birthplace

A. A. Co. Md.

MOTHER

14. Maiden name

Julia Speaks

15. Birthplace

A. A. Co. Md.

16. Informant

Addie E. Pumphrey

Address

Millersville Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan 20, 1948
(month) (day) (year)

Cemetery or crematorium

Green Haven Memorial

Location

Green Haven Md.

18. Funeral director

John M. Taylor, Son

Address

Annapolis Md.

19. Jan. 20, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 18, 1948

at

9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 14, 1948 to Jan. 18, 1948
 and that I last saw him alive on Jan. 18, 1948

Immediate cause of death

DURATION

Carcinoma of pyloric end of stomach causing obstruction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Taylor, M.D.
Annapolis, Md.

M. D. or other

Address

Date signed 1/19/48

RECEIVED
JAN 21 1948
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Duplicate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00139

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel Co.
 City or town Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 1/2 years
 Hospital, institution, or street address where death occurred:
Emergency Hospt.
 How long in hospital or institution? admitted at

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County A. A. Co.
 City or town Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5 Calvert St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war *****

3. (a) FULL NAME

Helen Queen

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

September 1909

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

38

5

hrs.

min.

9. Birthplace

Parole Md. A. A. Co.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

None

MOTHER FATHER

12. Name

Charles Queen

13. Birthplace

Parole Md.

14. Maiden name

Emma Wells

15. Birthplace

West River A. A. Co.

16. Informant

Mrs Daisy Cornor

Address

Parole Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof January 25, 1948
(month) (day) (year)

Cemetery or crematory

Brewer Hill Cemetery

Location

West St. Extd.

18. Funeral director

Mrs Charles E. Hicks

Address

45 Northwest St. Annapolis Md.

19.

Jan 23 48
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 20 1948 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 20 1948 to Jan. 20 1948
and that I last saw him alive on Jan. 20 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

E. Peyton Ritchings, M.D.
M. D. or otherAddress Annapolis, Md. Date signed Jan. 23, 1948

RECEIVED
JAN 24 1948
BT 4466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00140 23

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Glen Burnie, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...
 City or town... (If outside city or town limits, write RURAL and give nearest town)
 Street No... (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Lizzie Green

3. (b) Social Security Number

4. Sex F. 5. Color or race Black 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Husband is dead.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4 - 1887

8. AGE: Years 60 Months 1 Days 13 If less than one day hrs. min.

9. Birthplace Anne Arundel Co. Md.
 (Town, county, and state)
 10. Usual occupation Housework.

11. Industry or business

12. Name Mother FATHER Matthias Snowden

13. Birthplace Maryland

14. Maiden name Little Mattheus.

15. Birthplace Maryland.

16. Informant Leftie Snowden (Daughter)

Address Glen Burnie Md

17. Burial Date thereof Jan 22 - 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Md. Calvary

Location A.A. Co Md

18. Funeral director James A. Stages

Address 142 W. 11th St

19. 1/20 19 48 D.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 19 48 at 3 P. M.

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.H. Pachter M.D.

M.D. or other

Address Glen Burnie Md Date signed 11/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Millersville, Md. R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
2 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Severn Cross Roads
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel
 City or town... Millersville, R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Severn Cross Roads
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Gustave E. Reechel

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Marie A. Reechel
Nee; Neika 82 6. (c) If alive, give age 82 years
 7. Birth date of deceased (mo., day, yr.) August 28, 1863
 8. AGE: Years 84 Months 4 Days 14 It less than one day
hrs.min.

9. Birthplace... Danzig, Germany
 (Town, county, and state)
 10. Usual occupation... Carpenter (Retired)
 11. Industry or business Own Business
 12. Name... Carl Reechel
 13. Birthplace Germany
 14. Maiden name... Ludawikie Meyer
 15. Birthplace Germany

16. Informant... Mrs. Charles Green
 Address Millersville, Md. R.F.D.
 17. Burial Date thereof Jan. 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baldwin Memorial Ch. Yard
 Location Severn Cross Roads, Millersville
 18. Funeral director Thomas W. Singleton
 Address Glen Burnie, Md.

19. 1/15 1948 E. J. Joyce Locu
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948, at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 1947 to January 12 1948
 and that I last saw him alive on January 12 1948

Immediate cause of death Arterio-sclerotic Heart Disease
 DURATION 1 year

Due to.....

Due to.....

Other conditions chronic Nephritis 6 months

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

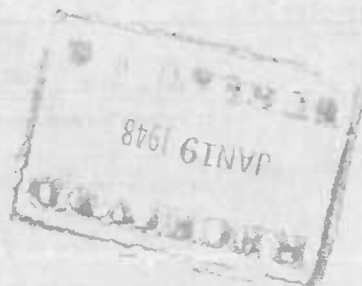
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward J. Cherritt M.D.
 M. D. or other
 Address Gambrells, Md. Date signed 1/13/48



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

00142

1. PLACE OF DEATH: County..... <u>Anne Arundel</u> City or town..... <u>Crownsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>2 yrs. 9 mos.</u> Hospital, institution, or street address where death occurred: <u>Crownsville State Hospital</u> How long in hospital or institution?..... <u>2 yrs. 9 mos.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>1045 Brantley Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>HARRY ROBERTS</u>				3. (b) Social Security Number			
4. Sex <u>male</u>		5. Color or race <u>negro</u>		6. (a) Single, married, widowed, or divorced <u>widowed</u>			
6. (b) Name of husband or wife -----				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>May 29, 1876</u>				8. AGE: Years <u>71</u> Months <u>9</u> Days If less than one day hrs. min.			
9. Birthplace <u>Maryland</u> (Town, county, and state)				10. Usual occupation <u>unknown</u>			
11. Industry or business -----				12. Name <u>Benjamin Roberts</u> (dead)			
13. Birthplace <u>Maryland</u>				14. Maiden name <u>Mary Taylor</u> (dead)			
15. Birthplace <u>Maryland</u>				16. Informant <u>Hospital records</u> Address..... <u>Crownsville, Md.</u>			
17. Burial (Burial, cremation, or removal. Which?) Date thereof..... <u>1/31/48</u> (month) (day) (year) Cemetery or crematory..... <u>Crownsville Memorial Pk</u> Location..... <u>Balto. Md.</u>				18. Funeral director <u>Geo. H. Kelson</u> Address..... <u>1303 Presstman St.</u>			
19. (Date rec'd by registrar) <u>1/30</u> 19 <u>48</u> <u>A.W. Hedrick</u> Registrar				20. DATE OF DEATH <u>January, 29</u> 19 <u>48</u> at <u>12:00</u> a.m.			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>4/23/45</u> 19 <u>45</u> to <u>1/29</u> 19 <u>48</u> and that I last saw him alive on <u>Jan. 29</u> 19 <u>48</u> Immediate cause of death..... <u>Myocarditis Chronic</u> <u>known to us since</u> <u>4/23/45</u> DURATION <u>4/23/45</u>							
Due to..... Due to..... Other conditions..... <u>Senile psychosis</u> <u>known to us since</u> <u>4/23/45</u> (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?..... Address..... <u>Crownsville, Md.</u> Date signed..... <u>1/29/48</u>							

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00143

1. PLACE OF DEATH:

County..... *a. a.*City or town..... *Severna*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Henry H. Schultz

3. (b) Social Security Number

219-16-1820

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Ira Schultz

7. Birth date of deceased (mo., day, yr.)

March 4, 1876

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*71**9**18*

hrs.

min.

9. Birthplace.....

Germany
(Town, county, and state)

10. Usual occupation.....

General Harmon

11. Industry or business.....

Unknown

MOTHER FATHER

12. Name.....

Unknown

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (a) Burial, cremation, or removal, which?

Burial

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

*Jan. 23, 1948**H. W. Hedrick*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... *Jan 21st* 19*48* at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan - 19 - 1945 to *Jan - 21 - 1948*
and that I last saw him alive on *Jan - 21 - 1948*

Immediate cause of death.....

Cerebral Haemorrhage

DURATION

4 days

Due to.....

Due to.....

Other conditions.....

Cerebral Sclerosis
(Include pregnancy within 3 months of death)*10 yrs.*

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Chas. L. Boe

M. D. or other

Address.....

Date signed *1-21-48*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00141

I. PLACE OF DEATH:

County *a a*
City or town *Harvey Landing*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *a a c s* County *Wm*
City or town *Harvey Landing*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

May Agnes Sears

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *W*

6. (b) Name of husband or wife *Wm Sears*

7. Birth date of deceased (mo., day, yr.) *Oct 22 1877* 6. (c) If alive, give age, years

8. AGE: Years *72* Months *2* Days *27* If less than one day hrs. min.

9. Birthplace *Wm*
(Town, county, and state)

10. Usual occupation *Domestic*

11. Industry or business

12. Name *Henry Jones*

13. Birthplace *Wm*

14. Maiden name *May E. Ireland*

15. Birthplace *Wm*

16. Informant *Owen Sears*

Address *Harvey Landing*

17. *Death* Date thereof *1/19/48*
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory *Friendship*

Location *Friendship, Md*

18. Funeral director *J. G. Hardisty & Son*

Address *Galleville, Md*

19. *1/19 48* (Date rec'd by registrar) *Wm. C. Taylor* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *1/17* 19 *48* at *3 A* M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 9* 19 *48* to *Jan 17* 19 *48*
and that I last saw him alive on *Jan 16* 19 *48*

Immediate cause of death *Cerebral hemorrhage* DURATION *10 days*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Wm C Taylor* M. D. or other

Address *Galleville, Md* Date signed *1/17/48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 21 1948
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

00145

95c

1. PLACE OF DEATH:

County Anne Arundel

City or town Winchester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or sleep address where death occurred:

Winchester Station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Winchester
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Ansell Rd.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Jerome E. Sherman

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Fairlie Eakin Sherman

7. Birth date of deceased (mo., day, yr.)

January 24th 1905

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

42

11

13

hrs.

min.

9. Birthplace

Massachusetts

(Town, county, and state)

10. Usual occupation

General Contractor

11. Industry or business

FATHER

12. Name

Alfred P. Sherman

13. Birthplace

Boston, Mass.

MOTHER

14. Maiden name

Elizabeth Jones

15. Birthplace

Boston, Mass.

16. Informant

Wm. J. E. Sherman

Address

Cornel Hall, Annapolis, Md.

17. Cremation

(Burial, cremation, or removal, Which?)

Date thereof

7/48
(month) (day) (year)

Cemetery or crematory

F. H. Lincoln Crematory

Location

Prince Geo. Co. Md.

18. Funeral director

John W. Taylor, Son

Address

Annapolis, Md.

19. Jan. 7

(Date rec'd by registrar)

19 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6, 1948 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination

Immediate cause of death

Acute dilatation of Heart

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

John M. Caffy M.D.
Annapolis Md.

M. D. or other

Date signed

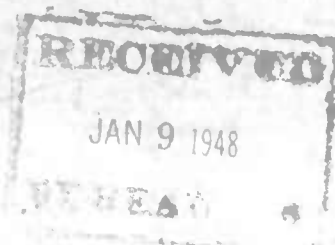
1-6-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

00146

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.
 City or town Germantown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 Years
 Hospital, institution, or street address where death occurred:
17 Brewer Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.A.
 City or town Germantown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 17 Brewer Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Frank Smith

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Ivah E. Smith
 6.(c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) March 30 1879
 8. AGE: 68 Years 9 Months 22 Days 18 If less than one day
 hrs. min.

9. Birthplace Smithville, Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Telephone Co.
 12. Name William Smith
 13. Birthplace Maryland
 14. Maiden name Lucy Childs
 15. Birthplace Maryland.

16. Informant Ivah E. Smith
 Address 17 Brewer Ave.
 17. Burial Date thereof Jan 21 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Bluff
 Location Annapolis, Md.
 18. Funeral director B.L. Hopping & Son
 Address 170 West Street, Annapolis, Md.
 19. Jan 24 19 48
 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 19 48 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 48, to Jan 21 19 48, and that I last saw him alive on Jan 21 19 48.

Immediate cause of death
Cerebral Hemorrhage
Rt Hemiplegia

DURATION

6 days
6 days

Due to _____
 Due to _____
 Other conditions Cerebral Hemorrhage
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other
 Address Annapolis Date signed 1-23-48

RECEIVED

JAN 27 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

926

00147

CERTIFICATE OF DEATH

Reg. Dist. No.

2/

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... P.O. Pasadena, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town...
(If outside city or town limits, write RURAL and give nearest town)Street No...
(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (a) FULL NAME

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Widowed

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

Sept. 23 - 1894

8. AGE:

Years

Months

Days

If less than one day

533

hrs.

min.

9. Birthplace

Anne Arundel County Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

William Spencer

13. Birthplace

Maryland

MOTHER

14. Maiden name

Charlotte Turner

15. Birthplace

Maryland

16. Informant

Widowed Spencer (wife)

Address

P.O. Pasadena, Md.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

1-21-48
(month) (day) (year)

Cemetery or crematory

Magdhy

Location

Anne Arundel Co. Md.

18. Funeral director

William B. Jackson

Address

916 Penna Ave. Balto 1.

19.

1/19
(Date rec'd by registrar)

19

48A.W. Hedrick

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1948, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947 to January 1948and that I last saw him alive on January - 16 1948

Immediate cause of death

Myocardial Insufficiency

DURATION

7 month

Due to

Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Executive H. P. Parker M.D.

M. D. or other

Address

Isle of Buena Vista, Md.Date signed 1/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
County.....
Crownsville
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County.....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 614 Stockton St.
(If rural, give LOCATION)
2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

ALBERT STENSON

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1877 8. (c) If alive, give age..... years

8. AGE: Years 70 Months -- Days -- If less than one day
..... hrs. min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Ransom

13. Birthplace.....

14. Maiden name Elizabeth Carter

15. Birthplace.....

16. Informant Hospital recordsAddress Crownsville, Md.17. Cremation Date thereof 1/10/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory London ParkLocation Federal Ave.18. Funeral director Metropolitan Funeral Home IncAddress 927 N. Mount St19. 1/8 88 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 19 48 at 9:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 5 19 47 to Jan. 6 19 48
and that I last saw him alive on Jan. 6 19 48

Immediate cause of death.....
Cancer of the penis Known to us since 8/5/47
..... since

Due to.....

Due to.....

Other conditions..... Known to us since 8/5/47
Psychosis with Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other

Address Crownsville, Md. Date signed 1/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Fort George G Meade
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:
 Station Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel
 City or town... Fort George G Meade
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... NC-135
 (If rural, give LOCATION)
 2.(a) If veteran, name war... World War II

3. (a) FULL NAME

JOHN SWARTZ

3. (b) Social Security Number

4. Sex... Male
 5. Color or race... White
 6.(a) Single, married, widowed, or divorced... Married
 6.(b) Name of husband or wife... Anna Swartz
 6.(c) If alive, give age... 41 years
 7. Birth date of deceased (mo., day, yr.)... 9 January 1906
 8. AGE: Years... 42 Months... 0 Days... 6 If less than one day... hrs. min.

9. Birthplace... Hazel, New York
 (Town, county, and state)
 10. Usual occupation... Soldier
 11. Industry or business

FATHER
 12. Name... George Swartz
 13. Birthplace... Lithuania
 MOTHER
 14. Maiden name... Eva Adamitis
 15. Birthplace... Lithuania

16. Informant... Service Record of deceased
 Address... Fort George G Meade, Maryland

17. Burial... Date thereof... 17 Jan 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory... Arlington National Crematory
 Location... Arlington, Virginia

18. Funeral director... Lily & Zeiler, Inc
 Address... 403 S. Wolfe St., Baltimore, Md

19. 15 Jan 1948
 (Date rec'd by registrar) JAMES N. GOERGEN CKPT 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH... 14 January 1948, at 0850 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 January 1948 to 14 January 1948

and that I last saw him alive on 0850 hrs 14 January 1948

Immediate cause of death... Cardio-vascular collapse

Due to... following spinal anesthesia

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Hemorrhoids external, internal, severe
 Date of op... 14 Jan 48

Autopsy results... Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... PAUL E. SIEBER CAPT. MC M. D. or other

Address... Ft. Geo G Meade Md Date signed... 15 Jan 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 16 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00150

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A. C.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. C.City or town Annapolis - Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 1118 Bay Ridge Ave. Catonsville Md.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mary R. Tydings

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

George R. Tydings

T. Birth date of

deceased (mo., day, yr.)

Feb. 17th 1855

6.(c) If alive, give age years

8. AGE:

921019

If less than one day

hrs. min.

9. Birthplace

Annapolis Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

George R. King

13. Birthplace

Annapolis, Maryland

14. Maiden name

Rebecca Hopkins

15. Birthplace

Annapolis, Maryland

18. Informant

Edward T. Tydings

Address

1118 Bay Ridge Ave. Catonsville Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 12, 1948
(month) (day) (year)

Cemetery or crematory

Edgar B. Clift Cemetery

Location

Annapolis, Maryland

18. Funeral director

John M. Taylor, Son

Address

Annapolis, Maryland

19.

(Date rec'd by registrar)

Jan 12 1948WW

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 8, 1948at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

April1947

to

Jan1948

and that I last saw her alive on

1/8/48Jan1948

Immediate cause of death

DURATION

Due to

Arteriosclerosis Generalized

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

UnsubscribedDate signed 1/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Prince GeorgesCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Chase Home - Md. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. Chase Home - Md. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Esther Ogles Warner

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Anthony R. Warner

7. Birth date of deceased (mo., day, yr.)

July 14th 1864

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8374

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Richard L. Ogles

13. Birthplace

Maryland

MOTHER

14. Maiden name

Fanny Knight

15. Birthplace

Vermont

16. Informant

3124

Address

Mr. P. L. Donoho
3124 Sigouia Ave Baltimore Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 21 1948
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore Md.

18. Funeral director

Address

John M. Taylor, Son
Annapolis Md.

19.

(Date rec'd by registrar)

Jan 20 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 18, 1948 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 13, 1948, to Jan. 18, 1948and that I last saw him alive on Jan. 18, 1948

Immediate cause of death

DURATION

Cardiovascular filar
air respiratory

Due to

Senility

Due to

Patient died of old age [24111 dec]

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchie
M. D. or otherAddress Annapolis, Md. Date signed Jan. 13, 1948

RECEIVED
JAN 21 1948
F. L. A. L. B.

Reg. Dist. No.

Address Julia Fokker - Pasadena Date signed Jan 17, 1917

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLE

Dr. Gallows

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00153

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Frederick
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Emergency Hospital
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind County Frederick
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Barry W. White

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mollie White7. Birth date of deceased (mo., day, yr.) July 11 1903 6.(c) If alive, give age 48 years8. AGE: Years 44 Months 4 Days 14 If less than one day hrs. min.9. Birthplace Somerset Co.
(Town, county, and state)10. Usual occupation Labor11. Industry or business 12. Name Major White13. Birthplace Ind.14. Maiden name White15. Birthplace Ind.16. Informant Mollie WhiteAddress R.F.D. 3 Annapolis17. Burial Date thereof Jan. 26 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory James QuarterLocation Deal Island18. Funeral director J. B. JohnsonAddress Annapolis19. Jan 26 48 Registrar W. H. Smith
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1948 at 3:55 P.M.21. I CERTIFY that death occurred on the date above stated; Post mortem Examination
January 25, 1948Immediate cause of death Coronary occlusion DURATION 1 hourDue to Coronary sclerosis Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? Deputy Medical Examiner23. SIGNATURE John M. Coffey M.D. M. D. Examiner
Address Annapolis, Md. Date signed 1-26-48

RECEIVED

JAN 27 1948

SE 6587

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00154

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH:

County Anne ArundelCity or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 64 yrs.Hospital, institution, or street address where death occurred:
Box 100 General Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural Waterbury P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BENJAMIN BRYAN WILLIAMS

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife Fannie Meade Williams7. Birth date of deceased (mo., day, yr.) October 1, 18838. AGE: Years Months Days If less than one day
64 3 27 hrs. min.9. Birthplace Waterbury A. A. Co. Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name R. Thomas Williams13. Birthplace Maryland14. Maiden name Fannie E. Bryan15. Birthplace Maryland16. Informant Mrs. Fannie Meade WilliamsAddress Waterbury, A. A. Co. Maryland17. Burial Date thereof Jan 31/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Baldwin MemorialLocation Millersville, Md.18. Funeral director Ben L. Hopping and SonAddress 170-172 West St. Annapolis, Maryland19. 30/48 19 E. J. Joyce Local
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 19 48 at 11:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 19 48 to 1-28 19 48and that I last saw him alive on Jan 28th 19 48Immediate cause of death Coronaryocclusion. DURATIONDue to Hemorrhage in thebase wall 30 min

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

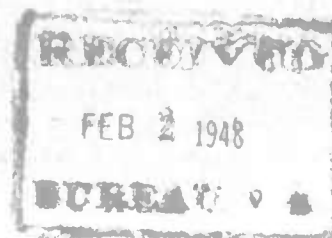
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ostman NewmanAddress Millersville Md. Date signed 1-29-48

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00155

22

1. PLACE OF DEATH:

County..... Anne ArundelCity or town..... Rural - Laurel
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 15 years +

Hospital, Institution, or street address where death occurred:

District Training SchoolHow long in hospital or institution?..... 15 years +

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington D.C.City or town..... Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No..... St. Elizabeth's Hosp.
(If rural, give LOCATION)2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

Mamie Alice Williams

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single6. (b) Name of husband or wife..... —7. Birth date of deceased (mo., day, yr.)..... 1890

6. (c) If alive, give age..... years

8. AGE: Years..... 58 Months..... — Days..... — If less than one day..... hrs. min.9. Birthplace..... Washington, D.C.
(Town, county, and state)10. Usual occupation..... none11. Industry or business..... none12. Name..... William Williams

13. Birthplace.....

14. Maiden name..... Anna Betty —

15. Birthplace.....

16. Informant..... D. J. J. recordsAddress..... Laurel Md17. Rural Date thereof..... 1/4/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... 1400 Chapin St. N.W.Location..... Wash. D.C.18. Funeral director..... Wm. Charles C.Address..... Washington D.C.19. Jan 24 19 48 Registrar..... Wm. Charles C.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1-24-48 19 48 at 2:18 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 18 19 34 to 1-24-48and that I last saw him/her alive on 1-23-48 19 48Immediate cause of death..... Pneumonia DURATION..... 3 daysDue to..... arterio-sclerosis 5 yrs.Due to..... Paralytic Agitation 5 yrs.Due to..... mental deficiency - imbecile lifeOther conditions..... arthritis since 1941..... cytotis since 1-12-48
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

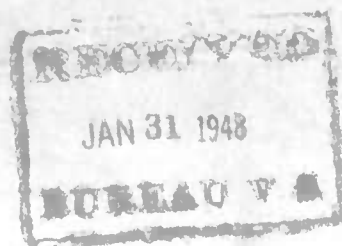
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... James S. S. M.D.Address..... Dist. Tr. School Laurel Date signed..... 1/24/48

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is, especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County... Anne Arundel County
 City or town... Pasadena
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Lifetime
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?... Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Anne Arundel
 City or town... Pasadena
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Bodkin Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war... no

3. (a) FULL NAME

Raymond Williams

3. (b) Social Security Number

216 12 9141

4. Sex... Male 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Married
 6.(b) Name of husband or wife... Bessie Williams
 6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... December 28, 1893
 8. AGE: Years... 54 Months... 0 Days... 17 It less than one day... hrs. min.

9. Birthplace... California
 (Town, county, and state)
 10. Usual occupation... Riveter
 11. Industry or business... Maryland Drydock
 12. Name... Unknown
 13. Birthplace... Unknown
 14. Maiden name... Unknown
 15. Birthplace... Unknown

16. Informant... Mrs. Bessie Williams
 Address... Bodkin Ave. Pasadena, Md.
 17. Burial Date thereof... Jan. 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Cemetery
 Location... Mt. Olivet, Baltimore, Md.
 18. Funeral director... Wm. Cook, Inc.
 Address... 1217 St. Paul Street, Baltimore, Md.
 19. 1-16 19 48 Supp...
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 13 1948 at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1948 to Jan 9 1948
 and that I last saw him alive on Jan 9 1948

Immediate cause of death... Generalized Acute
Peritonitis
 Due to... to the perforation

Due to... Carcinomatous secondary
to Carcinoma Common Bile
Duct
 Other conditions...

DURATION

12 hrs

(Include pregnancy within 8 months of death)

Major findings of operations... Carcinoma CommonBile Duct Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of... ..

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... P.W. Richards M. D. or otherAddress... 715 Catter Rd Date signed... 1/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne ArundelCity or town..... Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 21 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne ArundelCity or town..... Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)Street No..... 326 Railroad Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

WILLIAM A. WOODEY

3. (b) Social Security Number

216 05 8655

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... Jessie M. WoodeyNee Stallings 6. (c) If alive, give age..... 51 years7. Birth date of deceased (mo., day, yr.) December 9, 18818. AGE: Years Months Days If less than one day
66 1 7 hrs. min.9. Birthplace..... Baltimore, Md.
(Town, county, and state)10. Usual occupation..... Chauffer11. Industry or business..... Davidson Transfer & StorageFATHER 12. Name..... John Woodey13. Birthplace..... VirginiaMOTHER 14. Maiden name..... Dora Stumpf15. Birthplace..... Germany16. Informant..... Mrs. Jessie M. WoodeyAddress..... 326 Railroad Ave., Glen Burnie, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof..... Jan. 19, 48
(month) (day) (year)Cemetery or crematory..... Mayo CemeteryLocation..... Mayo, Maryland18. Funeral director..... Thomas W. SingletonAddress..... Glen Burnie, Md.19. 1/19 19. 48 L. J. DeAlba
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 16 19. 48 at 11.50 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
AUGUST 19. 47 to JAN 16 19. 48and that I last saw him alive on JAN 14 19. 48Immediate cause of death..... CORONARY THROMBOSIS

DURATION

Due to..... THROMBUS OF CORONARY
Blood vesselsDue to..... UNKNOWN

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Henry F. Zanger, M.D. M. D. or otherAddress..... Glen Burnie, Md. Date signed..... 1/17/48

RECEIVED
JAN 20 1948
BCHERO